Creating Beautiful Smiles
HOWE DENTAL

Name: _____

Today's Date ___/___/_____

Patient Information

Patient Name _____ Nickname _____
Last Name First Name MI

Birthdate ___/___/_____ SS# _____ ☐ Married ☐ Single ☐ Minor ☐ Male ☐ Female

Home Phone _____ Cell Phone _____ Work Phone _____

Address _____
Street City State Zip

Email Address ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

How would you like us to contact you? ☐ Phone ☐ Text ☐ Email How did you hear about our office? _____

Person Responsible for Account ☐ Husband ☐ Wife ☐ Mother ☐ Father ☐ Other _____

Family Information

HUSBAND (OR FATHER, IF A MINOR) Circle One

Last Name _____ First Name _____

Street _____ City _____ State ____ Zip _____

Home Phone _____ Work Phone _____

SS# _____ Birthdate ___/___/_____

Employer _____

WIFE (OR MOTHER, IF A MINOR) Circle One

Last Name _____ First Name _____

Street _____ City _____ State ____ Zip _____

Home Phone _____ Work Phone _____

SS# _____ Birthdate ___/___/_____

Employer _____

Person To Contact In Case of Emergency

Name _____
Last Name First Name

Home Phone _____ Cell _____ Email Address _____

Address _____
Street City State Zip

Insurance Information

PRIMARY

Do you have insurance to assist you with payment? ☐ Yes ☐ No

Subscriber's Name _____

Relationship _____ SS# _____

Birthdate ___/___/_____ Work Phone _____

Employer _____

Employer Address _____

Insurance Company _____ Group # _____

Have you used this insurance at a dental practice before? ☐ Yes ☐ No

SECONDARY (IF APPLICABLE)

Subscriber's Name _____

Relationship _____ SS# _____

Birthdate ___/___/_____ Work Phone _____

Employer _____

Employer Address _____

Insurance Company _____ Group # _____

Have you used this insurance at a dental practice before? ☐ Yes ☐ No

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Health Assessment

1. Are any of your teeth sensitive to: ☐ Cold ☐ Heat ☐ Sweets ☐ Biting Pressure
   Comments: _____
2. Do you have fluoride in your drinking water? ☐ Yes ☐ No
3. Does your jaw ever feel sore? ☐ Yes ☐ No Do you have TMJ /TMD? ☐ Yes ☐ No
4. Name of Physician: _____ Date of last visit: _____
5. Have you ever been hospitalized? ☐ Yes ☐ No If yes, please describe: _____
6. Have you taken any medicine during the past two years, including prescriptions, over-the-counter meds, vitamins, and herbal supplements? ☐ Yes ☐ No
   If yes, please list: _____
7. Are you allergic to or made sick by penicillin, aspirin, codeine, local anesthetics or any other drugs? ☐ Yes ☐ No
   If yes, please list: _____
8. Have you ever had a reaction to local anesthetics? ☐ Yes ☐ No
9. Do you have a reaction to metal jewelry or latex? ☐ Yes ☐ No
10. Have you ever had any excessive bleeding requiring special treatment? ☐ Yes ☐ No
11. WOMEN: a. Are you pregnant or are you trying to become pregnant? ☐ Yes ☐ No
    b. Are you nursing? ☐ Yes ☐ No
    c. Are you taking oral contraceptives? ☐ Yes ☐ No
12. Do you smoke or chew tobacco products? ☐ Yes ☐ No
13. Have you ever taken oral or IV Bisphosphonates (Boniva, Fosamax, Actonel, etc.)? ☐ No ☐ Yes Name: _____
14. Name of previous dentist: _____
15. Have you had orthodontic treatment? ☐ Yes ☐ No If yes, Dr. Name: _____
16. What is the main reason for your visit? _____
17. Do you like your smile? ☐ Yes ☐ No
18. If you could change anything about your smile what would it be? _____

Please check any of the following which you have had or have at present:

- ☐ Alcohol or Drug Dependency
- ☐ Allergies or Hives
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Arthritis or Swollen Joints
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Back Problems
- ☐ Birth Control Pills
- ☐ Blood Transfusion
- ☐ Cancer or Chemotherapy
- ☐ Cold Sores
- ☐ Congenital Heart Defect
- ☐ Cortisone Medicine (Steroids)
- ☐ Diabetes
- ☐ Emphysema or Bronchitis
- ☐ Epilepsy or Seizures
- ☐ Fainting or Dizzy Spells
- ☐ Glaucoma
- ☐ Heart Disease or Attack
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis (Type_____)
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaundice
- ☐ Kidney Trouble
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Medication for Weight Reduction
- ☐ Mental Health Problems
- ☐ Persistent Cough
- ☐ Pre-Medication for Dental Work
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Sexually Transmitted Disease
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis/Lung Disease
- ☐ Ulcers or other Gastrointestinal Problems

Do you have any medical condition or problem not listed above? ☐ Yes ☐ No

If yes, please list: _____

To the best of my knowledge, all of these answers are true and correct. If I have any change in my health, or if my medications change, I will inform Howe Dental at or prior to my next appointment.

_____ Signature of Patient or Guardian

_____ Date

Office Use BP: _____ Pulse: _____ ASA: _____ Allergies: _____ Pre-Med: _____ Initials: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the Notice of Privacy Practices from the office of Chad V. Howe, DDS. The Notice of Privacy Practices describes the type of uses and disclosures of my protected health information that may occur in my treatment, payment for services or in the performance of the office's health care operations. The Notice of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Notice of Privacy Practices is posted in the facility for disclosure.

Howe Dental reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. If there are changes, the office shall provide a copy of the revised Notice of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Notice of Privacy Practices by requesting that one be sent to me.

Name of Patient: _____ Date: _____

_____ Self Mother Father Relative Other: _____

Signature of Patient or Guardian — Relationship to Patient

Photo Release Form

I grant permission to Dr. Chad V. Howe and Associates, to use photographs or images taken of me for publication in brochures, promotionals, newsletters, and magazines, and to use the Photos on display boards, website, and to offer them for publications in other publications, without notifying me.

I further agree that Dr. Chad V. Howe and Associates may license others to use the Photo or any excerpts, and my name and likeness used in or identifying the Photos, and in any related or derivative versions of the Photos, and in the advertising, marketing and promotion of the Photos in all media throughout the universe. I agree to waive and release any and all claims against Dr. Chad Howe and Associates and its contractors and licensees relating to my name, my likeness, the Photos and their uses and/or distribution in any version or media throughout the universe, including without limitation, any rights and claims relating to royalties or compensation, editing, alteration, copyright, distribution, misappropriation, libel, false light, rights of privacy and / or publicity.

Name (please print): _____ Date: _____

Signature: _____ Date: _____

_____ Self Mother Father Relative Other: _____

Signature of Patient or Guardian — Relationship to Patient

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Financial Policy

In our continued commitment to provide the highest quality of dental care to all our patients and to have those services affordable, we are pleased to offer you these financial options and guidelines for payment:

- If you have insurance, we will gladly process your claims. We do require that you pay all estimated patient portions when services are rendered.
- It is the responsibility of the patient to know your individual insurance plan benefits.
- Any outstanding insurance benefits not received by this office within 90 days of date of service will be your responsibility. If you do not have insurance, full payment is expected as services are rendered.
- Every effort will be made to help you with your insurance. The estimated insurance coverage is not a guarantee of payment and the insurance company, not our office, determines the dental benefits you receive. Please keep your insurance information current by notifying us of any changes in employment and insurance coverage.
- For our patients without insurance a 5% cash courtesy will be offered if treatment is paid in full upon date of service.
- For procedures involving a laboratory step (i.e. crowns, dentures, night guards), 50% of the total fee is required before the case will be sent to the lab. Our office uses a high end lab, patients are responsible for all lab fees.
- Fees are guaranteed for 6 months from the date of your financial estimate.
- We accept Visa, MasterCard, Discover, American Express, personal checks, debit cards and cash.
- Financing is available through Care Credit, which offers interest free payment options for large treatment plans. Ask us for an application.
- 48 hours notice is required when re-scheduling or cancelling an appointment. A cancellation fee of $50 per half-hour will be assessed for any missed appointments.

Office Goal: Our office goal is to provide a comprehensive care plan, followed by a preventative maintenance schedule. We strive to present treatment and financial information prior to appointments, therefore eliminating lingering questions. We make every attempt to provide exceptional care in a comfortable environment. **Welcome to our office!**

Signature

I hereby agree that I am fully responsible for the total payment of all procedures performed in this office. I authorize the dental office to release records to my insurance company as needed for payment of dental benefits. I authorize my insurance benefits, if any, to be paid directly to the dental office.

_____ _____

Signature of Patient or Guardian | Date

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Office Financial Policies

As a condition of your treatment by this office, financial arrangements must be made in advance. This practice depends upon reimbursement from our patients for the cost incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment.

All emergency detail services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are rendered.

Patients who carry dental insurance understand that all dental services finished are charged directly to the patients and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collection received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be assessed on all accounts exceeding sixty (60) days from the date of service unless previously written financial agreements are made. Financial arrangements will only be accepted in the form of a credit card, which we will charge monthly. There will be a minimum charge of $2.00 for a balance under $200. I understand that the fee estimate listed for this dental care can only be extended for a period of six (6) months from the date of patient examination. I also understand that I will be charged for any appointment time that has been reserved for me, or my family if I do not contact your office within 48 hours.

In consideration for the professional services to be rendered to me (or, at my request, to my minor child or ward) by the dentist, I agree to pay the fee charged for the dental services provided by the dentist or licensed employee at the time the services are rendered, or within five (5) days of the billing if credit is extended by the dentist. In the event my account becomes delinquent, I agree to pay the remaining account balance plus the sum of the collection commission (40%) charged by the collection agency to whom a delinquent account is turned for collection, in addition to reasonable attorney fees and court costs where such legal services are necessary. I authorize the release of financial identification information concerning my account, including charges billed, payments made, and interest charges assessed, etc., to the dentist's collection agency or collection attorney should collection procedures become necessary.

I grant my permission to you or your assignee to telephone me at home or my workplace to discuss matters related to this form. I also agree to allow this office to leave messages concerning appointments and/or results on my answering machine or with a family member.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

I authorize the dentist or his designees to release financial identification information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.

I acknowledge that I have had an opportunity to read the "Office Privacy Policies" as provided by Chad V. Howe.
I understand the rights as defined by HIPPA.
I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

I agree to abide by the conditions outlined herein.

Patient Name: _____
(PLEASE PRINT)

Signature: _____ **Date:** _____
(PATIENT, LEGAL GUARDIAN OR AUTHORIZED AGENT OR PATIENT)

Witness: _____ **Date:** _____